

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred: —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3 Church Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Brown

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Widowed

6. (b) Name of husband or wife Dalie L. Brown

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 54 Months — Days — If less than one day
 hrs. min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation labor

11. Industry or business

12. Name John W. Atte13. Birthplace Virginia14. Maiden name Olta Woodley15. Birthplace Virginia16. Informant Edward JenkinsAddress Pocomoke City Md17. Burial Date thereof Dec 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Luke'sLocation Rural Pocomoke Md18. Funeral director Henry McDonaldAddress Pocomoke Md19. Dec 11, 47 Aune E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 47 at 7: P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 4, 47 to Dec 9, 47and that I last saw her alive on Dec 9, 47Immediate cause of death Lobar Pneumonia DURATION 2 wks.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis S. Cleveland, MD M. D. or otherAddress Pocomoke City, Md Date signed 12-11-47

RECEIVED

DEC 13 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11728

355

1. PLACE OF DEATH:

County Worcester
 City or town Berlin Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Worcester
 City or town Berlin Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION) no
 2.(a) If veteran, name war no

3. (a) FULL NAME

Ella Kate Briddell

3. (b) Social Security Number

no

4. Sex female 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife George Briddell
 7. Birth date of deceased (mo., day, y.) about 1882 6.(c) If alive, give age Don't know years
 8. AGE: Years 65 Months - Days - If less than one day - hrs. - min.

9. Birthplace Berlin Md
(Town, county, and state)10. Usual occupation House wife11. Industry or business Same as above12. Name Jessie Pitts13. Birthplace Berlin Md14. Maiden name Ella Pitts15. Birthplace Berlin Md16. Informant George BriddellAddress Berlin Md17. Burial Date thereof Dec 30 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin Md18. Funeral director James B StewartAddress Salisbury Md19. 12-29 47 Helen F Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Dec 19 47 at 12:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jun 19 47 to 26 Dec 19 47and that I last saw him alive on 26 Dec 19 47Immediate cause of death Pulmonaryedema & anasarca

DURATION

Due to Hypertensive heart 2 yrs
diseaseDue to atherosclerosis generallyOther conditions atherosclerosis generally

(Include pregnancy within 5 months of death)

Major findings of operations noDate of op. noAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herman R. Robbins MdAddress Berlin, Md Date signed 28 Dec 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Beaver Dam

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke P. D.

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Viana Hart

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mr. Frank Hart

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 18648. AGE: Years 83 Months 9 Days 14 It less than one day _____ hrs. _____ min.9. Birthplace Acco. Co. Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Alfred Simpson13. Birthplace Not Known14. Maiden name Melvina Hart15. Birthplace Acco. Co. Va.16. Informant Mrs. Tom CulpAddress Pocomoke P. D.17. Burial Date thereof Jan. 2, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory NelsonLocation New Church, Va.18. Funeral director N. A. ShieldsAddress New Church, Va.19. Jan. 3, 1948 Anne E. White

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1947 at 8 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20, 1947 to Dec. 31, 1947and that I last saw her alive on Dec. 30, 1947Immediate cause of death Translucal Pneumonia DURATION 10 daysDue to Senility

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis J. Cleveland, MDAddress Pocomoke City Date signed 1-3-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mo
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Clara Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Stingle Hearne

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White widow

6. (b) Name of husband or wife Ernest F. Hearne

6. (c) If alive, give age years

7. Birth date of deceased (mn., day, yr.) March 5 18788. AGE: Years Months Days If less than one day
69 9 25 hrs. min.9. Birthplace Wicomico Co., Maryland
(Town, county, and state)10. Usual occupation housework

11. Industry or business

12. Name George W. Moore13. Birthplace Maryland14. Maiden name Mary C. Wamwright15. Birthplace Maryland16. Informant Mrs. Eunice Esther Shockley
Address Snow Hill Maryland17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/48
(month) (day) (year)Cemetery or crematory Traskin Church CemeteryLocation Traskin, Md.18. Funeral director C. E. MessickAddress Bivalve, Md.19. (Date rec'd by registrar) 12/20/47 Registrar R. W. W. W. W. W.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1947 at 10.15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 25 1947 to December 30 1947 and that I last saw her alive on December 29 1947Immediate cause of death Cancer of uterine cervix DURATION 5 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Paul Cohen M.D.Address Snow Hill Md. Date signed 12/20/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important to physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11732

355

1. PLACE OF DEATH:

County Worcester
 City or town Berlin md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester
 City or town Berlin md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Leah Ellen Hudson

3. (b) Social Security Number

no

4. Sex female 5. Color or race aa 8. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Charles E Hudson
 7. Birth date of deceased (mo., day, yr.) Apr 16 1913
 6. (c) If alive, give age Don't know years
 8. AGE: Years 75 Months - Days - If less than one day hrs. min.

9. Birthplace Berlin md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Irving Gullin

13. Birthplace Berlin md

14. Maiden name Rachel Warren

15. Birthplace Berlin md

16. Informant Charles E. Hudson

Address Berlin md

17. Burial Date thereof Dec 22-1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin md

18. Funeral director James H. Stewart

Address Sababury md

19. 12-20 1947 Helen F. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1947 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

DURATION

Chr. Myocarditis

Due to

Due to

Other conditions Chr. nephritis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R. Law MD

M. D. or other

Address Berlin md Date signed 12-20-47

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DEC 24 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11733

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Minnie Catherine Merrill

3. (b) Social Security Number

4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Living Merrill7. Birth date of deceased (mo., day, yr.) June 23, 18866.(c) If alive, give age 67 years8. AGE: Years 61 Months 5 Days 25 If less than one day9. Birthplace Hudlestone Co. Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name W. R. Watson13. Birthplace Maryland14. Maiden name Mary Johnson15. Birthplace Maryland16. Informant Mr. Living MerrillAddress Berlin Md17. Burial, cremation, or removal, Which? Burial Date thereof 12/21/47

(month) (day) (year)

Cemetery or crematory EvergreenLocation Berlin Md18. Funeral director Anna A. BinkleyAddress Berlin Md19. 12-21- 47 Helen F. Hayward

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 19 47 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Dec 19 47 to 18 Dec 19 47and that I last saw h. alive on 18 Dec 19 47Immediate cause of death Acute coronary thrombosis

DURATION

4 daysDue to atherosclerosis generalized(arteriosclerosis)

Due to

Other conditions Coronary thrombosis2 yrs ago (include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE German A. Rabus

M. D. or other

Address Berlin, Md Date signed 22 Dec 47

RECEIVED

DEC 29 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11734

Reg. Dist. No. 354

1. PLACE OF DEATH:

County WorcesterCity or town Shackton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah Palmer

3. (b) Social Security Number

4. Sex Female5. Color or race Caucasian6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Nathan Palmer

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Jan — 18718. AGE: Years 76Months —Days —

If less than one day

hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housekeeper11. Industry or business unknown12. Name unknown13. Birthplace unknown14. Maiden name Ann Collich15. Birthplace Maryland16. Informant Rose HarmonAddress Princeton, Md.17. Burial, cremation, or removal, Which? BurialDate thereof Dec. 11, 1947
(month) (day) (year)Cemetery or crematory Home Burial SocietyLocation Shackton, Md.18. Funeral director Ernie BennettAddress Shackton, Md.19. Dec 9 1947 Mary M. Taylor
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County WorcesterCity or town Shackton
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 46 to Dec. 8 1947and that I last saw her alive on Dec. 6 1947Immediate cause of death Acute Pulmonary EdemaDURATION 1 dayDue to Hypertensive ChoreaBrain diseaseDue to SenilityOther conditions Chronic Nephritis

Exact diagnosis remains uncertain; however, best

opinion would be a diagnosis of cause of death Dec. 8, 1947

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

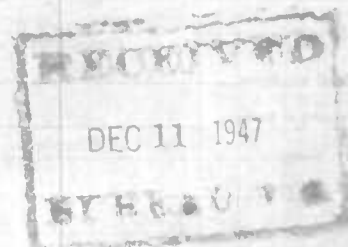
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. LaMar, M.D.Address Shackton, Md. Date signed 12-8-47

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John W. Sheppard.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Roseanne Sheppard6. (c) If alive, give age 76 years

7. Birth date of

deceased (mo., day, yr.)

Mar 12, 1861

8. AGE:

Years

Months

Days

If less than one day

8691

hrs. min.

8. Birthplace

Stockton, W. Va. Md.

(Town, county, and state)

10. Usual occupation

Retired Sea Captain

11. Industry or business

John Sheppard

12. Name

John Sheppard

13. Birthplace

Md.

14. Maiden name

Roseanne Sheppard

15. Birthplace

Md.

16. Informant

John W. Sheppard

Address

Berlin Md.

17. (Burial, cremation, or removal Which?)

BurialDate thereof 12/16/47

(month) (day) (year)

Cemetery or crematory

Berlin Md.

Location

Berlin Md.

18. Funeral director

Rev. D. Burdette

Address

Berlin Md.19. 12-16 1947

(Date rec'd by registrar)

Helen F. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Worcester

City or town

Berlin
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Dec 14 1947 at Berlin Md.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15th 1947 to 14th 1947and that I last saw him alive on 14th 1947Immediate cause of death CerebralHemorrhage

DURATION

3 daysDue to Generalized atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

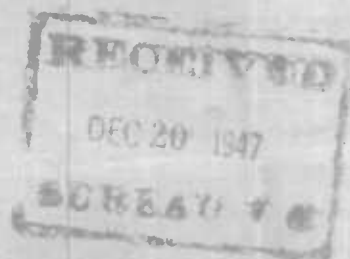
Means of injury

Injured at work?

23. SIGNATURE Herman M. H. H.

M. D. or other

Address 5 Bay St. Berlin, Md.Date signed 12/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830

11736

Reg. Dist. No.

355

1. PLACE OF DEATH:

County WorcesterCity or town Newark R.T.D.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah Ellen Spence.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Bruce Spence

7. Birth date of deceased (mo., day, yr.)

18726. (c) If alive, give age 68 years

8. AGE:

Years

Months

Days

If less than one day

75

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Charles R. Findley

13. Birthplace

md

14. Maiden name

Rachel Hammond

15. Birthplace

md

16. Informant

Bruce Spence

Address

Newark md R.T.D.

17.

(Burial, cremation, or removal. Which?)

Date thereof

12/9/47
(month) (day) (year)

Cemetery or crematory

German town

Location

Berlin md R.T.D.

18. Funeral director

James A. Burbo

Address

Berlin md

19.

12-9-
(Date rec'd by registrar)

19

Helen E. Hayward
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Worcester

City or town

Newark R.T.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 5

19

47

at

3 P

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on

Dec 2 -

19...

Immediate cause of death

DURATION

Due to

Cerebral

Due to

Hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Char. R. Law MD

M. D. or other

Address

Berlin mdDate signed 12-8-47

RECEIVED
DEC 11 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11737

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 912 Market St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Annie Elizabeth Tarr

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Lloyd W. Tarr

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 4. 1875

8. AGE: Years 72 Months 6 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Somerset County, Maryland
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name William Davis13. Birthplace Snow Hill, Maryland14. Maiden name Eliza Butler15. Birthplace Near Pocomoke City, Worcester Co16. Informant Mr Wilson K. BarnesAddress 111 Ridgewood Rd, Baltimore. Md.

17. Burial Date thereof 12/4/1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethany Methodist ChurchLocation Pocomoke City, Maryland18. Funeral director Howard A. GillAddress Pocomoke City, Maryland.

19. Dec 4 19 47 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2. 1947 2-15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947 to Dec 1947
and that I last saw him alive on Dec 1 1947

Immediate cause of death

Apnea of both lungs

DURATION

6 hrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Dec 4 1947 Date signed Dec 4 1947

CERTIFICATE OF DEATH

DECEASED

RECEIVED
DEC 6 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11738

Reg. Dist. No. 351

1. PLACE OF DEATH:

County Worcester
City or town Eden Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
City or town Eden
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Zulger

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1868

8. AGE: Years 79 Months 8 Days 0 If less than one day
..... hrs. min.

9. Birthplace Switzerland
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Alice Furrer15. Birthplace Switzerland16. Informant Emil ZulgerAddress Emil Zulger17. Burial Date thereof 12/18/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Parsons CemeteryLocation Salisbury Md.18. Funeral director State MarshallAddress Princess Anne Md.19. 12/16 47 ReRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15th 1947 at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death Dysentery

DURATION

Arterio Sclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Smith M. D. or otherAddress Princess Anne Md. Date signed 12/16/47

RECEIVED
DEC 19 1947